



Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name		First Name		Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #		
Allergies: <input type="checkbox"/> NKA or _____				
Street Address			City	
State	County	Zip Code		
Parent/Guardian		Day Telephone	Night Telephone	
Emergency Contact		Relationship	Telephone	

2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	
Supervising Physician's Name (If Required for Mid-Level Practitioner)		NPI Number	



Wilcox Home Infusion
250 Stratton Road
Rutland, Vermont 05701
Last Updated 10/2008

Fax Completed Form to:

Fax Number: 802-775-7824

Phone Number: 800-639-1210



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**Office of Vermont Health Access PRIOR AUTHORIZATION REQUEST
SYNAGIS® (PALIVIZUMAB)**

weeks:	days:	kg:	15mg/kg=	mg
Gestational Age		Current Weight	Dose	
		Wilcox Home Infusion	800-639-1210	802-775-7824
Diagnosis		Pharmacy	Phone	Fax
<input type="checkbox"/> Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under 12 months of age at the start of the RSV season.				
<input type="checkbox"/> Infants born at 29-32 weeks (i.e., between 29 weeks, 0 days and 32 weeks, 0 days) of gestation and under 6 months of age at the start of the RSV season.				
<input type="checkbox"/> Infants born at 32-35 weeks (i.e., between 32 weeks, 1 day and 35 weeks, 0 days) of gestation and under 6 months of age at the start of the RSV season (November 1) who have two of the following risk factors:				
<input type="checkbox"/> Child care attendance <input type="checkbox"/> School-aged siblings				
<input type="checkbox"/> Congenital abnormalities of the airways <input type="checkbox"/> Severe Neuromuscular Disease				
<input type="checkbox"/> Exposure to environmental air pollutants (e.g. exposure to wood burning heaters which are the primary source of heat for the family or passive household exposure to tobacco smoke)				
<input type="checkbox"/> Children under 24 months of age with chronic lung disease of prematurity (bronchopulmonary dysplasia) who have received medical therapy (supplemental oxygen, bronchodilator, diuretic or corticosteroid therapy) within 6 months prior to the start of the RSV season.				
<input type="checkbox"/> Treatment: <input type="checkbox"/> Dates of Use:				
<input type="checkbox"/> Children under 24 months of age with hemodynamically significant cyanotic or acyanotic heart disease:				
<input type="checkbox"/> Currently receiving medication to control heart failure				
<input type="checkbox"/> Having moderate to severe pulmonary hypertension				
<input type="checkbox"/> Having cyanotic heart disease				
<input type="checkbox"/> Other:				

NICU HISTORY

Did the patient spend time in the NICU?
☐ Yes ☐ No (If yes, please attach the NICU summary)
 Was RSV prophylaxis recommended by the NICU/Hospital physician for this patient?
☐ Yes ☐ No
 Was a NICU/Hospital /Clinic dose administered?
☐ Yes, Date(s): ☐ No

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PRESCRIPTION

Synagis (palivizumab) 50 and/or 100 mg vials and supplies for administration.
 Sig: Inject 15 mg/kg IM once every 4 weeks; expected date of first home injection: _____
 Dispense Quantity: Quantity sufficient for prophylaxis thru 04/09
 Deliver product to: ☐ MD office ☐ Patient's home ☐ Clinic
☐ Home health nurse to administer injection Home Health Agency: _____
 If delivery is to clinic, please give location: _____
 Pediatric Anaphylaxis: Administer 0.01 ml/kg (max 0.3ml) of 1:1000 epinephrine solution subcutaneously or intramuscularly, and contact EMS or physician, as appropriate.
 Other: _____
 Sig: _____
 Physician will monitor patient's response to therapy. Any complications in therapy will be reported to the physician either by the patient's caregiver, or the skilled nursing service (If other than physician's office or Wilcox Home Infusion)
Prescriber's Signature: _____ **Date:** _____
Supervising Physician's Signature: _____
 This order is valid for the entire upcoming season if signed prior to the November dose, or for the remainder of the present season if signed after November.